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Research Article

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Assessment of Mental Health Literacy among Adolescents of an Urban Slum in Delhi

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ABSTRACT

Introduction: By the age of 14 years, approximately half of the mental disorders set in, and the burden of mental health disorders is higher among those living in urban areas and belonging to poor socio-economic strata. Hence, the aim was to assess Mental Health Literacy, which includes recognition, help seeking and its barrier, first aid intention beliefs about prevention strategies, causes, treatment, stigmatizing attitudes, and social distance related to mental health.

Methodology: A cross-sectional vignette-based study was conducted among late adolescents (15-19 years). The self-administeredvignette-based questionnaire was used and vignettes were randomized among participants. MHL components such as recognition, help-seeking,barrier, first aid intentions, beliefs about prevention, causes, and treatment outcome along with stigma and social distancing related to mental disorders were measured. Correct labelling of the disorder was taken as the outcome of the study and multivariable regression was done.

Result: Of the 182 respondents, the percentage of mental health literacy among the respondents was very low, only 21.88% identified depression, and 1.16% identified schizophrenia. Study findings indicate that adolescents prefer to reach out more to informal sources such as close family members (42% overall). Adolescents had positive attitudes regarding most of the prevention strategies but beliefs about causes, treatment, and stigma were mostly negative. Household per month income and help seeking were found to be associated with correct recognition of the disorder.

Conclusion: There is a need to develop MHL among adolescents as well as among their parents as they are the preferred source of help seeking. Also school-based health literacy programs, public awareness using IEC materials and specifically targeted advocacy should be strengthened to decrease taboo and stigma among society and to reduce the treatment gap.

Key Words: Adolescents, Behavior, Mental Health Literacy, Mental health, Stigma, Vignette

INTRODUCTION

Adolescence is a critical period in the development and transformation of a child into an adult. Ensuring full support for all aspects of adolescent life is critical for encouraging the development of this transition and making a start for a healthy and productive life.[1] Across the world, the death rate among late adolescents, which is the age group of 15-19 years, is more as compared to those of early adolescents, which is the age range of 10-14 years. Among young people, mental health disorders are the leading cause of disability across all regions.[1]

Presently, India is home to 243 million i.e.21% nation's population is adolescents but unfortunately, 7.3% of India's adolescents suffer from mental morbidity (excluding tobacco use disorder) with a lifetime prevalence of 9.54%.[2] For adolescents living in India, self-harm is the chief cause of their death and could be attributed to destructive mental health issues of depression and anxiety among adolescents. Also, there is an enormous treatment gap varying from 73.6 percent for severe mental disorders, 85% for common mental disorders, and 91.1% for substance use disorders.[3]

WHOdescribes health literacy as "skills (both cognitive and social) which enable an individual to gain access, use and understand information to promote and maintain good health.[4] Mental Health Literacy (MHL) arising from the concept of health literacy has been described as knowledge, beliefs, and skills concerning mental or psychological disorders which facilitate their identification, and management and thus prevent the re-occurrence of episodes in the future.[5]

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The prevalence of mental disorders is high in India but they are typically neglected or misunderstood by the people. Most issues associated with mental health start throughout late childhood or early adolescence. Studies conducted recently, identified depression as the biggest contributor to the burden of disease among young people (DALYs).[1] This study will indicate the MHL among late adolescents, affecting correct recognition of disorder, stigma and social distancing related to mental health disorders, so that adolescents can be benefitted from educational intervention, to encourage them to seek help from appropriate sources and to abolish stigma pertaining to mental health.

METHODOLOGY

A cross sectional, vignette-based study was conducted to assess MHL among their outreach workers accompanied the investigator during data collection. Data was collected from Nilothi village, Chander Vihar slum and Jwalapuri slums. The participants for the study belonged to 15-19 years of age, who can read/ write/ understand English or Hindi. However, Adolescents who were diagnosed 6 months before or suffering from mental health issues were not considered for the study. The sample size take was 165.

According to a study done in southern India, the estimated prevalence of Mental Health Literacy assessed through vignettes was 29.04% for depression and 1.31% for schizophrenia.[6] Therefore, for calculating sample size prevalence was taken as 30%, with the precision of 7% and confidence interval of 95%. The sample size considered was 165. The sampling technique used was convenience sampling, wherein one individual was selected from each household.

Anonymous, vignette-based self-administered questionnaires were prepared. Vignettes used in this study are made according to Diagnostic and Statistical Manual (DSM) criteria. The questionnaire was made using existing literature, and previously established facts about mental health disorders. Vignettes were made using Diagnostic Statistical Manual (DSM) criteria and adapted from the National Mental Health Literacy Survey of Australia 2011. The study tools were finalized after a pre-test. One vignette, depicting either depression or psychosis/schizophrenia was given to the participant. Vignettes were randomized using the lottery method before giving them to the participant. The complete questionnaire was then modified according to Indian standards with the help of "Sangath", anorganization of national repute working on child development, adolescent and youth mental health, and chronic diseases.

Vignettes were adapted from the National Mental Health Literacy Survey of Australia 2011. Two vignettes were used in the study, based onthe most prevalent mental disorders among adolescents in India that is Depression and Schizophrenia, according to RKSK. One vignette consists of major depression and the other consists of Psychosis/Schizophrenia. These vignettes were randomized among participants using the lottery method.

Data entry was done using Epi Info to assess factors associated with the correct recognition of the disorder; the logistic regression method was used. Diagnostics for logistic regression, which are goodness of fit, multicollinearity and presence of influential outliers, were also run.

RESULTS

1. Recognition of the disorder:

Assessment of MHL though vignettes turned out to be very low among late adolescents. Only 21.88 % labeled depression correctly and only 1.16% labeled schizophrenia correctly. If considered alternate labels because of young age and limited exposure of adolescents, such as; for depression mental illness and emotional problems and for schizophrenia psychosis, mental illness and emotional problems; the recognition of vignette improves (Table 1).

Table 1: Distribution of respondent's ability to identify mental health conditions

Options (N=182)	Depression=96 n (%)	Schizophrenia=86 n (%)
Depression	21 (21.88)	15 (17.44)
Schizophrenia	1 (1.04)	1 (1.16)
Psychosis	8 (8.33)	6 (6.98)
Mental illness	22 (22.92)	18 (20.93)
Stress	17 (17.71)	17 (19.77)
Nervous breakdown	2 (2.08)	3 (3.49)
Cancer	2 (2.08)	3 (3.49)
Emotional problem	8 (8.33)	10 (11.63)
No problem	15 (15.63)	13 (15.12)

2. Help seeking intentions and barriers to help seeking:

2.1 Help seeking intentions:

This section highlights where adolescents suffering from mental health condition could seek help from if they had problem similar to person shown in vignette. The results show that for both vignettes help from informal sources, close family member (45.83% and 38.37% respectively) was most common.

Second choice of help for depression as well as for schizophrenia is doctors (20.83% and 16.28%). However, another interesting finding while seeking help for schizophrenia was adolescents equally prefers close friends (16.28%) as much as doctors.

When asked whether they would tell their parents while facing similar problems 87.91% said that they would (Table2).

Table 2: Sources of help seeking to address depression and schizophrenia

Sources (N=182)	Depression=96 n (%)	Schizophrenia=86 n (%)
General physician (counsellor/psychiatrist/family doctor)	20 (20.83)	14 (16.28)
Teacher	13 (13.54)	12 (13.95)
Close family member	44 (45.83)	33 (38.37)
Close friend	7 (7.29)	14 (16.28)
Deal alone	4 (4.17)	7 (8.14)
Religious leaders/Babas	3 (3.13)	1 (1.16)
Information from internet	5 (5.21)	5 (5.81)

2.2 Barrier to help seeking:

Figure 1 outlines what respondents think might act as a barrier in availing mental health services or seeking help from a person. Responses were same for depression and schizophrenia.

Cost of treatment is the most common barrier identified by adolescents for both Depression and Schizophrenia (31.25% and 25.28% respectively) (Figure 1).

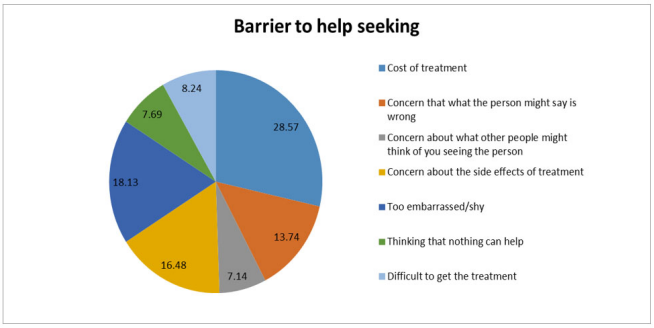

Figure 1: Percentage of what respondents think might stop them from seeking help from the person or service for depression and schizophrenia.

3. First aid intentions:

In this section participants were asked about what they would do if the person described in the vignette was someone they cared about or was close to them. For both vignettes, "Listen to his/her problem in an understanding way" was the most commonly identified action (41.67%) for depression and 37.21% for schizophrenia).

This was followed by "Encouraging him/her to become physically active" for depression (16.67%) and "Accompanying him/her to doctor" for schizophrenia (20.93%) (Table 3).

Table 3: Percentage of respondents reporting first aid intentions

Intention	Depression=96 n (%)	Schizophrenia=86 n (%)
Listen to his/her problem in an understanding way	40 (41.67)	32 (37.21)
Talk to him/her firmly about getting his/her act together	3 (3.13)	2 (2.33)
Accompany or encourage them to seek professional help (doctor, psychiatrist, etc.)	15 (15.63)	18 (20.93)
Suggest her/him to have few drinks/marijuana to forget troubles.	8 (8.33)	9 (10.47)
Cheer him/her up	4 (4.17)	5 (5.81)
Ignore them until he/she gets over it.	4 (4.17)	4 (4.65)
Keep him/her busy to keep his/her mind off problems	6(6.25)	9(10.47)
Encourage him/her to become more physically active	16 (16.67)	7 (8.14)

4. Beliefs about specific prevention, causes and treatment outcome:

4.1 Belief about prevention:

Table 4 highlights respondents' ratings of the helpfulness and non-helpfulness of interventions. On assessing prevention strategies for mental disorder, "Keeping regular contact with family" was rated most helpful for depression (85.42% for helpfulness). For schizophrenia, "Keeping regular contact with friends" was rated most helpful response (80.23% for helpfulness). This was followed by "Keeping physically active" for both vignettes (81.25% for depression and 78.57% for schizophrenia).

Every intervention was considered helpful in both the vignettes except for "Having religious or spiritual beliefs". On one hand people receiving depression vignette considered "Having religious or spiritual beliefs" as helpful (61.46%) where as those receiving schizophrenia vignette considered it as not helpful (53.49%). For both vignettes cutting down alcohol/tobacco/marijuana was considered not helpful (Table 4).

Table 4: Attitude toward prevention of mental disorder for depression and schizophrenia

Intervention	Depression=96 n (%)		Schizophrenia=86 n (%)	
	Helpful	Not helpful	Helpful	Not helpful
Having religious or spiritual belief	59 (61.46)	37 (38.54)	40 (46.51)	46 (53.49)
Making regular time for relaxing activities e.g. yoga	73 (76.04)	23 (23.96)	66 (76.74)	20 (23.26)
Keeping regular contact with family	82 (85.42)	14 (14.58)	65 (75.58)	21 (24.42)
Keeping regular contact with friends	74 (77.08)	22 (22.92)	69 (80.23)	17 (19.77)
Avoiding situations that might be stressful	56 (58.33)	40 (41.67)	48(56.47)	37 (43.53)
Keeping physically active	78 (81.25)	18 (18.75)	66 (78.57)	18 (21.43)
Cutting down tobacco/weed/alcohol	41 (42.71)	55 (57.29)	34 (39.53)	52 (60.47)

4.2 Beliefs about cause of mental health:

This section highlights respondents' views about the likelihood factor as the cause of the mental disorders described in the vignettes. For both vignettes, "Being a nervous person" (31.25 % for depression and 39.53% for schizophrenia) was believed to be the likely cause of having either depression or schizophrenia. This was followed by "Chemical imbalance in brain" for Depression (16.67%). For Schizophrenia, responses were similar for three options, whichwere"Chemical imbalance in brain, Traumatic life events and Exams/career" (10.47% for each option) (Table 5).

Table 5: Percentage of respondent's reporting cause of mental disorders

Options	Depression=96 n (%)	Schizophrenia=86 n (%)
Being a nervous person	30 (31.25)	34 (39.53)
Chemical imbalance in brain	16 (16.67)	9(10.47)
Inherited or genetic causes	3 (3.13)	3 (3.49)
Problems from childhood	6 (6.25)	3 (3.49)
Traumatic/stressful life events	11 (11.46)	9 (10.47)
Day to day problems such as family arguments	12 (12.50)	8 (9.30)
Exams/career	4 (4.17)	9 (10.47)
Relationships	6 (6.25)	4 (4.65)
Virus/Infections	3 (3.13)	1 (1.16)
Bad deeds	1 (1.04)	3 (3.49)
Usage of alcohol/ marijuana/ tobacco	4 (4.17)	3 (3.49)

4.3 Beliefs about treatment outcome:

Figure 2 shows respondents' views if the person described in the vignette had appropriate professional help. 47.80% considered that person in the vignette will fully recover with disappearance of problem whereas 36.81% considered that person in the vignette will recover but problems will reappear. A small but significant number (11.54%) still have negative perception about getting medical treatment (Figure 2).

Figure 2: Respondents views about getting mental health treatment.

4. Stigmatizing attitude and social distance related to mental health

4.1 Attitude toward mental disorder:

Across both the vignettes, "problem shown in vignette is a sign of personal weakness" is the one where respondents were least agreed (18.68%). "Problem is a real medical illness" was the statement with which most respondents agreed (56.04%). To the question who suffers more from such sort of problems, respondents answered that women suffer or have more mental disorders (65.93%) but beliefs that unemployment is not contributing to mental health issue (76.92% answered no to the question related to unemployment).

A notable point was that 87.91% agreed that they would not tell third person, if they had the problem described in the vignette (Table 6).

Table 6: Respondents' agreement with statements reflecting attitudes to those with mental illness

Thoughts	Response	
	Yes n (%)	No n (%)
If I had this problem I would tell third person	22 (12.09)	160 (87.91)
People with this problem are unpredictable	83 (45.60)	99 (54.40)
Avoid people with this problem	50 (27.47)	132 (72.53)
People with this problem are dangerous	75 (41.21)	105 (58.79)

Table 6: ***(Continued)***

Thoughts	Response	
	Yes n (%)	No n (%)
Problem is a real medical illness	102 (56.04)	80 (43.96)
Problem is a sign of personal weakness	34 (18.68)	148 (81.32)
Would unemployed people suffer more from this sort of problems?	42 (23.08)	140 (76.92)
Who would suffer more from such sorts of problems? Men or women?	Men 62 (34.07)	Women (65.93)

4.2 Social discrimination and social distance:

When respondents were asked, "would community discriminate against such individuals described in vignette" 54.95% answered positively saying yes, community will discriminate. (Figure 3).

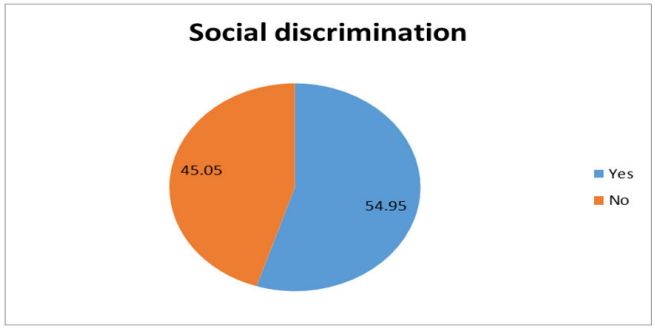

Figure 3: Percentage of respondents who answered that person will face social discrimination.

This section shows the percentage of respondents who were either "willing" or "unwilling" to interact socially with the person described in the vignette. This section greatly highlights how stigmatised mental health issues are. Respondents said "no" to every option that they neither want to develop friendship/go to their house/ invite them nor wanted to work with them.

Majority (67.58%) did not want to work with such individuals, followed by refusing to develop friendship with them and going to their house (62.09% each) (Figure 4).

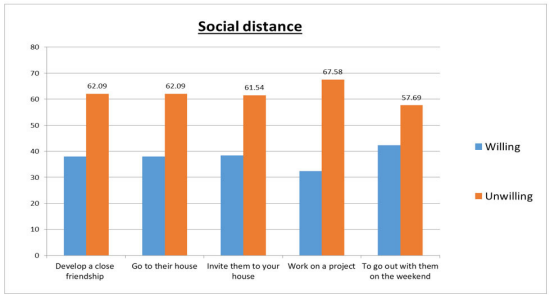

Figure 4: Percentage of respondents views on social distance related to mental health.

DISCUSSION

The aim of this study was to assess Mental Health Literacy (MHL) among 15-19 years old with special focus on their naïve knowledge of depression and schizophrenia. MHL was assessed using vignettes, which were randomized among 182 participants.

Recognition of the disorder:

Results showed that MHL assessed through vignettes was very low. Only 21.88% identified and labeled depression correctly and 1.16% identified and labeled schizophrenia correctly. If we consider alternate labels while assessing MHL such as mental illness and emotional problems for depression and psychosis, mental illness and emotional problems for schizophrenia the percentage of correct labeling goes up. Correct identification of depression increases by 31.25% and correct identification of schizophrenia increases by 39.54% but there is presence of sufficient literature stating that labeling a person as mentally ill will contribute to stigmatizing attitude which ultimately act as a barrier in receiving treatment.[7] Depression was more correctly identified as compared to schizophrenia but approximately 17% also labeled schizophrenia as depression which suggests how the term depression is over-generalized.

A few interesting findings were that an overall 18.63% of respondents labeled both these mental disorders as stress and 15.38% labeled it as no problem. This is of concern because when people do not use correct labels for describing mental disorders such as depression or schizophrenia and use labels such as stress or any other life problem they tend to normalize the situation and which in turn is less expected to promote professional help-seeking. For instance, it was also concluded in a study that people who labeled depression vignettes with labels other than depression were more likely to be agreed that they can handle their problem by themselves rather than seeking professional care.[7]

The multivariable model showed an association between household per month income and help seeking with correct identification of the disorder. Adolescents who belong to higher income strata and those who knew that they should seek help from formal sources for problems described in the vignette were able to recognize the disorder more correctly. A borderline association of past exposure to mental health disorders was also found with correct recognition of disorder in the vignette which is quite logical because if a person experienced a mental disorder prior at some point in his/her life is more likely to handle it in a better way in future by recognizing it correctly. Then the person should be able to comprehend the difference between mental disorders with daily life stresses and should know when and how a problem becomes a mental disorder.

Help seeking and barriers to seeking help:

When asked where participants could seek help if they had a problem similar to the person shown in the vignette, most (42% overall) nominated close family member as their preferred source for seeking help followed by seeking help from doctors (overall 18.68%) and then teachers (overall 13.74%). In case where respondents received schizophrenia vignette help seeking from close friend, (16.28%) was reported equally with help seeking from doctors. Therefore, in conclusion, adolescents preferred seeking help more from informal sources rather than seeking help from formal sources.

Findings highlight the important role family and friends play in life of an adolescent and how important it is to educate them. Although it is good for an adolescent that he/she is seeking help from family and friends but the concern arises when this is done in place of seeking professional help. Another major area of concern arises for those who seek help from friends. Adolescent's peers may not have enough experience and maturity to facilitate professional help seeking or provide them with good advice or guidance, which in turn might result in more damage.[8]

School teachers were the third most reported response (overall 13.74%) presumably because a great percentage of the participants were school-going (92.86%) and therefore were more familiar with their school teachers. Given that adolescents are increasingly using the internet to seek information, only five percent consider this method of help seeking. It is possible that adolescents simply do not associate this method of help seeking with emotional or mental difficulties. [8] On a positive note, it is heartening to see that approximately 19% of the adolescents were opting for doctors as their choice of help, which could be a major first step towards getting appropriate help for mental disorders.

Concern about the cost of treatment was the most common barrier to adolescents for help seeking. This finding could be confounded because most of the respondents belong to the strata that were earning less than 20,000 per month. Embarrassment or shyness was the second most common response as a barrier to help-seeking which is consistent to previous findings.[9]

First aid intentions:

Apart from being able to deal with one's own mental health problems, focus should also have laid on how best one can help or assist and support peers and community. As data indicates that there are numerous people who experience mental disorders, fail to acknowledge what is happening to them, and delay professional help-seeking for a long period, thus contributing to the high treatment gap and adolescents are one such category that bear the load of it. In such circumstances, the social network of a person could be helpful in facilitating recognition, help-seeking and treatment preferences. Assisting others in promoting recognition and help seeking is therefore particularly essential during adolescence. This is the age when most of the mental disorders first sets in and because of poor knowledge and experience adolescents are often unable to take optimal action. Helping, assisting and supporting others in recognition and help-seeking in case of mental disorders is called mental health first aid.[7]

The question asked was what participants would do if person in the vignette is someone they knew and cared about to which majority (overall 39.5%) opted that they would listen to problems in an understanding way. Adolescents' strong endorsement of above-mentioned first aid may be due to its simplicity, inexpensive nature and less stigma attached to it. The concern, however, is that this form of first aid help does not involve participation of any adult which then may delay seeking professional help.[10]

Only 18% (overall) suggested professional help and some (overall 9%) suggested potentially unhelpful things like recommending use of alcohol/marijuana/tobacco to forget his or her inconveniences. These results support the conclusion that there is substantial need to improve mental health first aid knowledge and understanding.

Beliefs about prevention strategies, causes and treatment outcome:

Prevention strategies: Prevention strategies for mental disorders are undeniably one of the least developed domains of MHL. Across both vignettes respondents showed similar response except for having religious beliefs and thus disparity was observed between depression and schizophrenia vignette. For cutting down of deleterious habits, adolescents considered it as not helpful. The main highlighting point here is despite various health interventions given in the area about mental health and nutrition, majority (overall 59%) consider that cutting down of alcohol/tobacco/marijuana is not helpful in preventing mental health disorders. There is considerable presence of literature to prove how harmful is consumption of alcohol[7] and it may also have led new type of mental health disorder which is substance abuse, another very common mental disorder among adolescents.[3]

Cause: Just like cause of heart diseases, cancer could be many, similarly for mental disorders causes could be many but one should understand that it's the presence of social and inherited causes which are far more important than physical causes.[11] When asked about what causes mental health disorder as described in the vignette, being a nervous person was the most nominated response (overall 35.16%). Chemical imbalance in brain (overall 13.74%) followed as second leading cause. Although the most nominated response showed that adolescents believed mental disorders as a result of physical cause. However, second most common cause highlight that adolescent did acknowledge social and inherited cause as well.

Those who received schizophrenia vignette responses were similar for three options which were chemical imbalance in brain, exams/career, and traumatic life events (10.47 percent each). This finding highlights how important it is to have a stable career or good academic life along with less conflict in family. Literature also links that clashes or disagreements between parents and offspring can cause increase risk of psychological distress among child.[7]

Treatment outcome: Around half of the respondents (48%) believed that if the person described in the vignette had suitable professional help she/he will fully recover with disappearance of problem. Although a small number, (approximately 15%) was not optimistic about getting medical treatment and believed in no improvement and condition getting worse. Such negative attitude towards treatment outcome may ultimately lead decrease service utilization and increased treatment gap. Even though in India we have evidence based cost-effective interventions for treatment of mental health disorder,[3] mere presence and having access to treatment options is not enough to ensure that people in need will adhere to treatment. People should believe that what healthcare professionals offer is likely to help them and motivation to get treatment should come within or from closest family member or friend without being judged or stigmatized, otherwise it will hamper their chances of seeking out for help and coping or adhering with treatment recommendations.

Stigmatizing attitude towards people suffering from mental disorders:

Although stigma is not a component of MHL but is always been considered in relation to MHL. Considering problem as a sign of personal weakness was the option for which participants were least agreed (approximately 19%) and mostly agreed upon that yes problem in the vignette is a real medical condition (56%). This could be taken as a positive sign that adolescents knew scenarios described in vignette were medical conditions and not personal weakness. Presence and prevalence of stigma in the society could be appreciated when majority (88%) agreed that they would not tell any third person if they were facing similar problem as described in vignette. Majority (approximately 65%) responded that women suffer more from problems described in the vignette which provide evidence that gender based studies assessing MHL are needed to be done in future.

Social discrimination and distance towards people with mental disorders:

For social discrimination most of them were responded that person in the vignette will face discrimination by the public. When given with depression vignette 61.46% answered for social discrimination while the numbers were less for schizophrenia (47.67%) despite having more stigma attached with it. It may be because adolescents were not aware about schizophrenia and thus had no knowledge about it.

Questions about social distancing were also a proof about how our society perceived mental health. Respondents were unwilling to make any kind of relationship with the person described in the vignette, which highlight that mental health disorders are still considered a taboo in the society and people refrain to talk or establish any contact with the person who is suffering from such disorders. Community perceptions, stigma and social distance related to mental health results in overall delay in getting professional help or treatment and is a major demand side barrier contributing in huge treatment gap in India.[3]

MHL is comparatively is new and has a short history of research therefore this study will thus contribute in the current pool of evidence. Since burden of mental health disorders is higher among urban dwellers and those belong to lower income quintiles, it is of utmost importance to explore and improve MHL levels among urban slum dwellers and the current study is one of a kind study where MHL among urban slum dwellers was assessed. Also by the age of 14 half of mental health disorders sets in therefore improving adolescent's MHL is important which was done in this study. Mostly studies conducted on adolescent's MHL did not assess stigma. It is the uniqueness of the study that stigma and social distancing related to mental health disorders among adolescents was also assessed. Vignettes were randomized among participants thus reducing bias. Few questions such as adolescent's belief that women suffer more from mental health disorders provide basis for the future research specially keeping gender perspective in picture.

Few methodological restrains such as use of non-probability sampling technique (convenience sampling) and sample size being 182 because of which generalizability could be an issue. Although careful and consultative adaption was employed during the translation of questionnaire, ensuring the equivalence of meaning across language could be an issue. Hence, it is likely that some questions were not elucidated as planned. Vignettes were presented in written format with all the symptoms and its period clearly stated, thus probably it was easier for participants to identify the problem more easily. It should also be acknowledged that adolescents participating in this research belong to community in which Mamta-HIMC was providing interventions and thus imparting knowledge, so their views are not necessarily representative of all adolescents dwelling in urban slums.

CONCLUSION

Most significantly, India's developmental agendas should see mental health as a priority. Health and other sectors such as institutions, welfare, commissioning sector and other pro-

grams and policies should encompass and incorporate mental health agenda in their respective policies, schemes and programs. Eventually the goal is to make a world where people suffering from mental disorders are gallant and knowledgeable enough that they will be able to take swift action when mental health adversities arise by seeking help from formal and professional sources. A world where people can receive and cohere with evidence based or verified treatments, where people are aware of mental health first aid, preventive actions and strategies to so that not only themselves but their families, peers and community could be benefitted, where support is readily provided by others in their social network without prejudice and stigma and where mental health services are perceived as making a substantial contribution that merits public support.

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Authors Contribution: This work was carried out in collaboration among all five authors. Author and Alam Ayesha and Zaidi Ilham, designed the study and author Alam Ayesha and Chaudary Shikhar, wrote the protocol, and Anjum Sahifa and Panda Salinee wrote the first draft of the manuscript, managed the literature searches. Alam Ayesha, Zaidi Ilham, Chaudhary Shikhar, Anjum Sahifa and Panda Salinee read and approved the final manuscript.

REFERENCES

1. Adolescents and mental health. World health Organisation. 2019 [cited 20 February 2020]. URL http://www.who.int/maternal_child_adolescent/topics/adolescence/mental_health/en.
2. Chadda RK.Youth & mental health: Challenges ahead. Indian J Med Res. 2018 Oct; 148(4):359-361.
3. Gururaj G, Varghese M, Benegal V, Rao GN, Pathak K, Singh LK. National Mental Health Survey of India, 2015–16 (NIMHANS, editor). NIMHANS Publication, Bengaluru. 2016. [cited 20 February 2020]. https://main.mohfw.gov.in
4. Track 2: Health literacy and health behaviour.7th Global Conference on Health Promotion: Track themes. World health Organisation.[cited 20 February 2020]. URL https://www.who.int/healthpromotion/conferences/7gchp/track2/en.
5. Jorm AF, Korten AE, Jacomb PA, Christensen H, Rodgers B, Pollitt P. "Mental health literacy": a survey of the public's ability to recognise mental disorders and their beliefs about the effectiveness of treatment. Medical Journal of Australia. 1997 Feb; 166(4):182-6.
6. Ogorchukwu JM, Sekaran VC, Nair S, Ashok L. Mental health literacy among late adolescents in South India: What they know and what attitudes drive them.Indian J Psychol Med. 2016 May; 38(3):234-41.
7. Jorm AF. Mental health literacy: empowering the community to take action for better mental health. Am Psychol. 2012 Apr; 67(3):231.
8. Burns JR, Rapee RM. Adolescent mental health literacy: young people's knowledge of depression and help seeking. J Adolesc. 2006 Apr 1; 29(2):225-39.
9. Gulliver A, Griffiths KM, Christensen H. Perceived barriers and facilitators to mental health help seeking in young people: a systematic review. BMC psychiatry. 2010 Dec; 10(1):1-9.
10. Singh S, Zaki RA, Farid ND. A systematic review of depression literacy: Knowledge, help-seeking and stigmatising attitudes among adolescents. J Adolesc. 2019 Jul 1; 74:154-72.
11. Reavley NJ, Jorm AF. Recognition of mental disorders and beliefs about treatment and outcome: findings from an Australian national survey of mental health literacy and stigma. Aust N Z J Psychiatry. 2011 Nov; 45(11):947-56.